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91-1631

Supreme Court, U.S.
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No. _____

IN THE

Supreme Court of the United States

October Term, 1991

ST. MARY'S HOSPITAL, INC.,

Petitioner,

v.

ARKANSAS BLUE CROSS AND BLUE SHIELD
A MUTUAL INSURANCE COMPANY,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

CHARLES R. NESTRUD
CHISENHALL, NESTRUD & JULIAN, P.A.
400 West Capitol Avenue, Suite 2840
First Commercial Bank Building
Little Rock, Arkansas 72201
(501) 372-5800
Attorney for Petitioner

TREVATHAN PRESS • LITTLE ROCK

QUESTION PRESENTED

1. WHETHER THE ARKANSAS GENERAL ASSIGNMENT STATUTE, CODIFIED AT ARK. CODE ANN. §4-58-102, AS CONSTRUED BY THE ARKANSAS SUPREME COURT, SUFFICIENTLY 'RELATES TO' ERISA PLANS SO AS TO BE PREEMPTED UNDER ERISA.

LIST OF ALL PARTIES

The parties to this action are St. Mary's Hospital, Inc., which is a wholly owned subsidiary of American Medical International, Inc., and Arkansas Blue Cross and Blue Shield, a mutual insurance company.

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TO THE HONORABLE THE CHIEF JUSTICE AND THE ASSOCIATE JUSTICES OF THE SUPREME COURT OF THE UNITED STATES:

The Petitioner, St. Mary's Hospital, Inc. ("St. Mary's"), prays that a Writ of Certiorari issue to review the judgment of the United States Court of Appeals for the Eighth Circuit entered in the above-entitled case on October 30, 1991.

OPINIONS BELOW

The opinion of the Eighth Circuit Court of Appeals is reported at 947 F.2d 1341 (8th Cir. 1991) and is reproduced as Appendix I to this Petition. The opinion of the United States District Court for the Eastern District of Arkansas, Little Rock Division, is not reported but is reproduced as Appendix II to this Petition. The order denying Petitioner's Petition for Rehearing with Suggestion for Rehearing en Banc, dated January 13, 1992, is reproduced as Appendix III. The opinion of the Supreme Court of Arkansas is reported at 299 Ark. 514, 773 S.W.2d 831 (1989) and is reproduced as Appendix IV to this Petition. The decree of the Chancery Court of Pope County, Arkansas is unreported and is reproduced as Appendix V to this Petition.

JURISDICTION

The decision of the United States Court of Appeals for the Eighth Circuit was entered on October 30, 1991. The Appellee's Petition for Rehearing with Suggestion of Rehearing en Banc was denied on January 13, 1992. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1), as cases in the courts of appeals may be reviewed by the Supreme Court by Writ of Certiorari granted upon the petition of any party to any civil case, before or after rendition of judgment or decree.

STATUTES INVOLVED

The relevant statutory provisions are Section 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1144(a) and Ark. Code Ann. §4-58-102).

ERISA Section 514(a) Supersedure; effective date. Except as provided in subsection b of this Section, the provisions of this subchapter and subchapter III of this Chapter shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in Section 1003(a) of this title and not exempt under Section 1003(b) of this title.

ERISA, Section 514(b)(2)(A) Construction and Application. Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law or any state law which regulates insurance, banking or securities.

Ark. Code Ann. §4-58-102. Assignment of certain instruments authorized. All bonds, bills, notes, agreements, and contracts, in writing, for the payment of money or property, or for both money and property, shall be assignable.

STATEMENT OF THE CASE

On July 27, 1987, the Petitioner, St. Mary's Hospital, Inc. ("St. Mary's"), along with its parent, American Medical International, Inc. ("AMI"), brought an action for declaratory judgment against Arkansas Blue Cross and Blue Shield ("BCBS") in the Chancery Court of Pope County, Arkansas ("Chancery Court"). The action sought a declaration that BCBS was required to honor assignments of insurance proceeds made by St. Mary's patients, notwithstanding the fact that St. Mary's had not and has not executed a provider contract with BCBS. BCBS refused to honor assignments made by St. Mary's patients and, instead, made payments of policy proceeds directly to the insureds, in contravention of the executed written assignments. BCBS contended that it was allowed under its insurance contract and the Arkansas Insurance Code to make payment of policy proceeds directly to the insureds, regardless of the presence of an assignment in favor of St. Mary's. AMI and St. Mary's argued that the Arkansas General Assignment Statute, codified at Ark. Code Ann. §4-58-102 ("the Assignment Statute") controlled. Both parties filed motions for summary judgment.

The Chancery Court entered a summary judgment in favor of BCBS. The Chancery Court held that there was an irreconcilable conflict between the provisions of the Arkansas Insurance Code and the Assignment Statute, and that the provisions of the Insurance Code prevailed over the Assignment Statute. Accordingly, the Chancery Court held that BCBS could refuse to honor

patient assignments. AMI and St. Mary's appealed.

The Arkansas Supreme Court reversed the Chancery Court's decision; held that the Assignment Statute, rather than the Arkansas Insurance Code, applied to the action; and held that BCBS was required to honor those assignments. *See American Medical International, Inc. v. Arkansas Blue Cross and Blue Shield*, 299 Ark. 514, 773 S.W.2d 831 (1989). A copy of the Supreme Court of Arkansas' decision appears as Appendix IV to this Petition. The Arkansas Supreme Court then remanded the action to the Chancery Court for proceedings not inconsistent with the appellate mandate.

On remand, the Chancery Court scheduled the matter for trial on BCBS' claim that the Assignment Statute should be overridden by a healthcare cost containment public policy. A trial on the "public policy" issue was held in the Chancery Court on December 21, 22, 27, and 28, 1990. The Honorable Andre McNeil, sitting as Special Chancellor of the Chancery Court, in a final decree filed on August 26, 1991, held that the 1989 decision of the Arkansas Supreme Court fully and finally determined that BCBS was required to honor St. Mary's patients' assignments of insurance proceeds. A copy of the Chancery Court's decision appears as Appendix V attached to this Petition. The Chancery Court proceeded to reject BCBS' "public policy" claim, finding that BCBS failed to prove that its assignment restriction practice was supported by any public policy. Specifically, the Chancery Court found "that the proof offered by [BCBS] falls short

of proving that it [the assignment restriction] is an effective method of reducing costs in view of healthcare standards for the State of Arkansas." Appendix V at p. 2. The Chancery Court specifically concluded that BCBS' proposed public policy does not override the insured's right to assign insurance proceeds under Ark. Code Ann. §4-58-102, as interpreted by the Arkansas Supreme Court.

BCBS commenced this collateral action for declaratory relief in the District Court on February 8, 1990, nearly three years after the state court action was commenced, and over six months after the Arkansas Supreme Court decision.[1] In this collateral action, BCBS seeks a declaratory judgment that ERISA authorizes BCBS to ignore the Assignment Statute for those policies covered by ERISA. St. Mary's responded to BCBS' Complaint for Declaratory Relief with a Motion to Dismiss.[2] St. Mary's contended that BCBS should be precluded from raising the issue of ERISA preemption or, in the alternative, that ERISA does not preempt the Arkansas Statute because the Assignment Statute does not sufficiently "relate to" employee benefit plans.

The District Court held that the Assignment Statute is not preempted by ERISA. Because the District

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1. At no time in the state court action did BCBS raise the ERISA preemption issue.

2. Because exhibits were attached to the Motion to Dismiss, the court below properly treated the Motion to Dismiss as a Motion for Summary Judgment. See, Memorandum and Order, Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital, U.S.D.C. No. LR-C-90-89 (December 19, 1990), Appendix II at p. 1, note 1.

Court did not find ERISA preemption, it did not reach the issue of whether or not BCBS had waived the preemption issue by failing to raise it timely in the prior state court proceeding. BCBS appealed to the United States Court of Appeals for the Eighth Circuit.

The Eighth Circuit reversed the dismissal of the District Court, finding a sufficient nexus between the Assignment Statute and ERISA employee welfare benefit plans to warrant preemption. The Eighth Circuit remanded for further findings on the issues of whether the Assignment Statute was saved from preemption by the "savings clause," 29 U.S.C. §1144(b)(2)(A), and whether BCBS has waived the preemption defense by failing to raise it timely in the state court litigation.

The Eighth Circuit found that the only issue before it was whether the Assignment Statute "relates to" ERISA plans.[3] In finding that the Assignment Statute "relates to" ERISA plans, the court looked to the totality of the state statute's impact on the plan. The factors that were considered by the court were: a) whether the Assignment Statute negated a plan provision; b) the effect on primary ERISA entities and impact on plan structure; c) intrastate and interstate impact on plan administration; d) economic impact; and e) other statutory provisions.

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3. As set forth above, the Eighth Circuit did not decide the question of whether ERISA preempts the Assignment Statute because the case was remanded for a finding by the District Court on the issue of whether the Assignment Statute is exempted from ERISA preemption by the savings clause. ERISA, §514(b)(2)(A), 29 U.S.C. §1144(b)(2)(A). Appendix I at p. 4.

The court held that, while none of these factors was, in and of itself, determinative on the issue, the totality of the Assignment Statute's impact on the plan provided sufficient basis for a finding that the Assignment Statute "relates to" ERISA plans. The court specifically distinguished this Court's decision of *Mackey v. Lanier Collection and Service, Inc.*, 486 U.S. 825 (1988).[4] The Eighth Circuit, in refusing to apply *Mackey* to the facts of the instant case, purported to distinguish between "garnishments" which, under *Mackey*, are permissible alienations, and "assignments" which, according to the Eighth Circuit, are not.

Additionally, the Eighth Circuit purported to distinguish *Mackey* on the basis that this Court relied upon the ERISA "sue and be sued" clause as support for its finding that ERISA does not preempt state garnishment laws and that, because the "sue and be sued" clause has no relevance here (as assignments do not involve judicial proceedings), the court concluded that *Mackey* is inapplicable. The court further distinguished *Mackey* on the basis that Congress could not have intended that ERISA plans govern the right of creditors to garnish benefits while such a statement does not hold true for "voluntary assignments." Based upon its distinctions of the *Mackey* decision, together with its review of the factors which it considered in deciding the preemption issue, the court found that there was a sufficient nexus between the As-

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4. In Mackey, this Court held that Georgia's garnishment statutes did not sufficiently "relate to" ERISA such that the garnishment statutes were preempted by ERISA.

signment Statute and ERISA health and welfare plans such that the Assignment Statute "relates to" those health and welfare plans within the meaning of the ERISA preemption statute. 29 U.S.C. §1144(a).

St. Mary's filed a Petition for Rehearing with Suggestion for Rehearing en Banc on November 27, 1991. St. Mary's contended that the Eighth Circuit, in reversing the decision of the District Court, issued an opinion which directly conflicts with this Court's decision of *Mackey*. In addition, St. Mary's contended that the opinion rendered by the Eighth Circuit referred to and relied upon matters not apparent of or contained in the record of the proceedings below, and requested that its petition for Rehearing be granted with a suggestion that the matter be reheard en banc. On January 13, 1992, the Eighth Circuit denied St. Mary's Petition for Rehearing and Petition for Rehearing en Banc. For the reasons below, the Petitioner seeks a Writ of Certiorari to review the judgment of the United States Court of Appeals for the Eighth Circuit.

REASONS FOR GRANTING THE WRIT

I. THE EIGHTH CIRCUIT COURT OF APPEALS HAS DECIDED AN IMPORTANT FEDERAL QUESTION WHICH HAS NOT BEEN, BUT SHOULD BE, SETTLED BY THIS COURT.

Under Article VI, Clause 2 of the Constitution, the laws of the United States are the supreme laws of the land. The supremacy clause prohibits states from enacting legislation inconsistent with federal law, and also prohibits them from enacting any law in a particular area if Congress has intended to preempt state regulation. *Napier v. Atlantic Coastline Railroad Co.*, 272 U.S. 605 (1926). Because problems of preemption by definition involve conflicts between federal and state authority, they are particularly appropriate for resolution by this Court. *Mackey*, 486 U.S. at 828; *Local 926, International Union of Operating Engineers v. Jones*, 460 U.S. 669 (1983); *Chicago and Northwestern Transportation Co. v. Kalo Brick and Tile Co.*, 450 U.S. 311 (1981); *Hisquierdo v. Hisquierdo*, 439 U.S. 572 (1979).

In the labor and employment area in particular, this Court is frequently called upon to decide questions of federal preemption of state law. *Mackey*, 486 U.S. 825; *Sears, Roebuck & Co. v. United Brotherhood of Carpenters*, 436 U.S. 180 (1978); *San Diego Building Trades Council v. Garmon*, 359 U.S. 236 (1959). Questions as to the preemptive effect of the Employee Retirement Income Security Act recently occupied the attention of the Court.

F.M.C. Corp. v. Holliday, _ U.S. _, 111 S.Ct. 403 (1990); *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987); *Mackey*, 486 U.S. 825; *Shaw v. Delta Airlines*, 463 U.S. 85 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

While preemption may be either expressed or implied, *Fidelity Federal Savings and Loan Association v. DeLacuesta*, 458 U.S. 141 (1982), the ERISA preemption cases in this Court have focused on ERISA's expressed preemption provision. *Shaw*, 463 U.S. at 96 (1983). Although Section 514, the ERISA preemption provision, is broad, the Court has recognized that it does contain some limitations. *Mackey*, 486 U.S. 825; *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985).

The Eighth Circuit Court of Appeals held that the Arkansas Assignment Statute, as construed by the Arkansas Supreme Court, is preempted by ERISA. This ruling is in conflict with the ruling of the Arkansas Supreme Court holding that the Assignment Statute requires that insurers honor all assignments of insurance proceeds. *American Medical International*, 773 S.W.2d 831; *see also, National Mutual Casualty Co. v. Cypert*, 207 Ark. 11, 179 S.W.2d 161, 164 (1944), and cases cited therein; *accord, Gisela Investments v. The Liberty Mutual Insurance Co.*, 452 So.2d 1056 (Fla. App. 1984). The Arkansas legislature is powerless to overturn the Eighth Circuit's determination that the statute is preempted. The Arkansas courts have found that, as a matter of **state** public policy, the Arkansas legislature does not allow an insured's right to

assign insurance proceeds freely to be overridden by an anti-assignment clause. However, the Arkansas Supreme Court is likewise powerless to overturn the Eighth Circuit's determination to the contrary, insofar as ERISA health and welfare benefits are concerned, despite the state ruling that there is no matter of state public policy more important than an insured's right of free assignability. There is a very real danger that the legislature's intent, on this matter of state policy regarding free assignability, will be frustrated by the Eighth Circuit's decision.

In addition to the above issues concerning matters of state public policy, the question presented here, which involves directly a healthcare provider's right to be paid, is certainly an important one. Congressional concerns regarding the future of the healthcare system in America cannot be overstated. *See* H.R. Rep. No. 241, 99th Cong., 2d Sess. 44, reprinted in 1986 U.S. Code Cong. & Admin. News 579, 622; *National Companies Health Plan v. St. Joseph's Hospital*, 929 F.2d 1558 (11th Cir. 1991). There have been numerous reports of the growing number of Americans without any healthcare coverage, and hospitals are facing staggering problems with Medicaid/Medicare reimbursement rates and amounts, leading to a decreasing willingness of the nation's hospitals to provide care to those who cannot afford to pay. To place upon hospitals the burden of collecting monies which the insurer has agreed to pay, and which the patients have assigned to them directly, only adds to the problem. Appendix I at p. 3. Clearly, this is an important federal question which has not been, but should be, settled by this

Court, rendering certiorari review appropriate pursuant to Rule 10 of the Rules of the United States Supreme Court.

II. THE EIGHTH CIRCUIT COURT OF APPEALS HAS DECIDED A FEDERAL QUESTION IN A WAY WHICH CONFLICTS WITH APPLICABLE DECISIONS OF THIS COURT.

The Writ should also be granted because the Eighth Circuit Court of Appeals has decided a federal question in a way which conflicts with applicable decisions of this Court, specifically, *Mackey*, 486 U.S. 825. As set forth above, *Mackey* held that ERISA does not preempt state garnishment procedures. The *Mackey* precedent is clearly applicable to this case by virtue of the presence of a statutory assignment mechanism, and therefore, the Eighth Circuit decision conflicts with this Court's decision of *Mackey*.

Perhaps the most important conflict is apparent when the Eighth Circuit opinion is considered in light of its practical effect on assignments of plan benefits in Arkansas. If the decision, in its current form, remains the law, the result will be that BCBS (and other Arkansas plan administrators) will be required to honor assignments of insurance proceeds emanating from non-ERISA group benefit plans and from individual insurance policies, while being excused from honoring assignments of

proceeds from ERISA plans.[5] This result directly conflicts with the Supreme Court's holding in *Mackey*, 486 U.S. 825. In *Mackey*, this Court specifically held that a state's statutorily mandated scheme for the collection of monies owed must remain untouched and unpreempted by ERISA. Arkansas' Assignment Statute is purely and simply a statutorily mandated scheme for the collection of monies due. The Arkansas Assignment Statute was impermissibly allowed by the Eighth Circuit to be affected by ERISA, in direct conflict with *Mackey*, 486 U.S. 825.[6]

Furthermore, the Eighth Circuit found that the fact that Congress' failure to include the pension anti-assignment provision in the health and welfare benefit portion of ERISA somehow provided support for its finding that Congress intended that health and welfare benefits be non-assignable, at the option of the Administrator.

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5. BCBS' declaratory judgment action pertains only to those plans which are governed by ERISA. In fact, BCBS admitted during oral argument before the Eighth Circuit that its action did not purport to include non-ERISA benefits such as those payable under individual policies of insurance or those payable under non-employer-based group policies of insurance. See, 29 U.S.C. §1002(1) ("employee welfare benefit plan" and "welfare plan" includes only plans established or maintained by an employer or employee organization). The record below is clear that the Assignment Statute applies in Arkansas to individual policies as well as group policies. Appendix IV at pp. 3-4. Accordingly, those BCBS policies and plans which do not come within the provisions of ERISA would not be preempted by this action.

6. The Eighth Circuit's distinction of the Mackey decision, which upholds state garnishment statutes, yields an absurd result which this Court could not have intended. St. Mary's may sue the patients, obtain a judgment and garnish BCBS for the insurance proceeds according to Mackey but may not obtain those proceeds through a non-judicial assignment according to the Eighth Circuit decision. Furthermore, because of the Eighth Circuit decision, a third party judgment creditor may garnish BCBS and obtain the insurance proceeds earned by the hospital and assigned to the hospital, because the Eighth Circuit would invalidate the hospital's prior claim to those insurance proceeds through assignment, while Mackey would allow garnishment by a third-party creditor. Surely this Court did not intend this result.

Again, this finding directly conflicts with the holding of this Court in *Mackey*, where this Court stated:

> Ultimately, in examining [the relevant provisions of ERISA], there is no ignoring the fact that, when Congress was adopting ERISA, it had before it a provision to bar the alienation or garnishment of ERISA plan benefits, and chose to impose that limitation only with respect to ERISA pension benefit plans and not ERISA welfare benefit plans. In a comprehensive regulatory scheme like ERISA, such omissions are significant ones.

486 U.S. at 837.

Contrast the holding of this Court with the following language which appears in the Eighth Circuit's October 30, 1991 decision:

> In fact, the pension benefit anti-assignment provision actually supports a finding that the assignment statute 'relates to' ERISA plans. The legislative history of ERISA indicates that Congress intended to preempt the field of employee benefit law. *See, Shaw*, 463 U.S. at 99 (citing from 120 Cong. Rec. 29197, 29933 [1974]). The fact that Congress explicitly addressed the assignability of pension benefits in ERISA indicates that the issue of benefit assignment, whether pension or welfare, is within the area of law Congress intended to preempt.

Appendix I at p. 19.

Thus, the Eighth Circuit's finding that Congress' omission of an anti-assignment provision for welfare benefit plans supported its application of the anti-assignment provision to health and welfare benefits directly conflicts with the finding of this Court that the omission is "significant." *See, Mackey*, 486 U.S. at 837. Furthermore, this finding directly conflicts with the clear mandate of ERISA, that assignments and alienations be barred **only** as to pension proceeds. It is clear that the decision of the Eighth Circuit as to the federal question of ERISA preemption conflicts with the decision of this Court in *Mackey*. Consequently, this Court should grant certiorari review to decide this important question and resolve the conflict.

III. THE EIGHTH CIRCUIT COURT OF APPEALS HAS RENDERED A DECISION WHICH CONFLICTS WITH THE DECISION AND ANALYSIS OF ANOTHER UNITED STATES COURT OF APPEALS ON THE SAME MATTER.

Finally, the writ is proper because the Eighth Circuit decision conflicts with a Ninth Circuit decision on a similar issue.

In *Davidowitz v. Delta Dental Plan of California, Inc.*, 946 F.2d 1476 (9th Cir. 1991), the Ninth Circuit held that ERISA does not require free assignability but based that decision, in part, on a lack of state authority speaking

to the right of assignment.[7] In *Davidowitz,* certain dentists who did not participate in a non-profit healthcare service plan brought an action against the plan seeking a preliminary injunction ordering the plan to honor patients' assignments of their welfare benefit payments for non-participating dentists. The United States District Court granted the preliminary injunction motion, and the plan appealed.

In the decision rendered on October 28, 1991, the Ninth Circuit reversed. The Ninth Circuit held that ERISA does not affirmatively mandate assignability of welfare benefit plan payments notwithstanding an express plan provision prohibiting assignment; that ERISA welfare plan payments are not assignable in the face of an express non-assignment clause in a plan; and that the plan did not breach any fiduciary relationship by including the non-assignment clause. Notably absent, however, in the *Davidowitz* opinion, is any state statutory requirement rendering welfare benefit plan proceeds assignable. In contrast, Arkansas has an express statute rendering all rights to payment of money assignable. Accordingly, in Arkansas parties cannot override that legislative pronouncement through private contracts. It would appear that, had the Ninth Circuit been presented with a California Assignment Statute, which prohibited assignment restriction clauses in insurance contracts, the result may well have been different. Significantly, the *Davidowitz*

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7. Unlike the situation here, the Davidowitz case arose specifically pursuant to the provisions of ERISA.

court rejected an analogy between garnishment cases, such as presented in *Mackey*, and voluntary assignment cases, as presented both here and in *Davidowitz*, for the sole reason that, with voluntary assignment cases, there was no state law mechanism providing for statutory assignment. The Ninth Circuit held that the "garnishment" cases, such as *Mackey*, hold that state law may provide a statutory mechanism for judgment collection, and such state procedure is not preempted by ERISA. Because voluntary assignments were not, under *Davidowitz*, statutorily mandated, the Court concluded that the *Mackey* decision was inapplicable. However, where, as here, there is a state, statutorily mandated procedure governing assignments, which renders all assignments enforceable, and negates all assignment restriction clauses, the garnishment cases provide ample support for a federal holding leaving the state statutory mechanism intact. Had there been a state assignment statute present in *Davidowitz*, a review of the opinion indicates that the result may have been different and that the different result would have directly conflicted with the Eighth Circuit's decision here.

The analysis is further highlighted by a review of *Washington Hospital Center Corp. v. Group Hospitalization and Medical Services, Inc.*, 758 F.Supp. 750 (D.D.C. 1991), a decision noted by the *Davidowitz* court as the only other federal pronouncement on this issue. In *Washington Hospital*, the Court noted specifically the absence of any statutory or other pronouncement governing the issue:

> However, neither ERISA nor any ERISA

> case cited by the parties or located by this Court squarely addresses the validity of an anti-assignment clause in a case such as this one. District of Columbia statutes and precedent are said by the parties to be equally silent on the precise issue.

758 F.Supp. at 752. Furthermore, the Court noted that neither side offered clear public policy arguments in favor of or against overriding the anti-assignment clause. Contrast that with the situation presented here, where the Arkansas legislature, as the final arbiter of state public policy, by enacting the Assignment Statute, has established a public policy of free assignability of proceeds from insurance policies. The Arkansas Supreme Court has consistently held that assignment restriction clauses in insurance contracts are void. *Cypert*, 179 S.W.2d 161, 164. While the scale may have been somewhat balanced in the *Washington Hospital* and *Davidowitz* cases, those courts considered the existence of state public policy to be relevant to its analysis and may well have found a different result if they had been presented with a situation where the legislature had established, by statute, that free assignability overrides assignment restriction clauses. Moreover, in this case, BCBS was not able to persuade the Arkansas courts that its assignment restriction clause was effective in reducing healthcare costs, and the court found no public policy support for the assignment restriction clause. Appendix V at p. 2. Because consideration of that issue should have governed the decision of the Eighth Circuit, and did not, this Court should grant certiorari review in order to resolve this issue.

IV. CONCLUSION

This Court, in *Mackey*, dictated that matters involving state statutorily mandated schemes for the collection of monies due are to remain untouched and unaffected by ERISA. The Eighth Circuit has impermissibly allowed federal intervention into the traditionally state-controlled area of debt collection, in direct contravention to this Court's dictate in *Mackey*. Such a result must not be allowed to stand. For the foregoing reasons, Petitioner prays that a Writ of Certiorari be issued to review the judgment and decision of the United States Court of Appeals for the Eighth Circuit in this case.

Respectfully submitted
CHISENHALL, NESTRUD & JULIAN, P.A.
Suite 2840
400 West Capitol Avenue
Little Rock, Arkansas 72201
(501) 372-5800
By CHARLES R. NESTRUD
Arkansas Bar No. 77095

APPENDICES

APPENDIX I

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 91-1097EA

Arkansas Blue Cross and Blue Shield,
A Mutual Insurance Company,

Appellant

v.

St. Mary's Hospital, Inc.,

Appellee.

Appeal from the United States District Court
for the Eastern District of Arkansas.

Submitted: September 11, 1991
Filed: October 30, 1991

Before BOWMAN, MAGILL, and LOKEN, *Circuit Judges.*

MAGILL, *Circuit Judge:*

Arkansas Blue Cross and Blue Shield (BCBS) appeals from a declaratory judgment of the district court holding that the Employment Retirement Income Security Act of 1974 (ERISA) does not preempt the Arkansas assignment statute, as the assignment statute applies to

welfare benefits payable under the ERISA plans.[1] We reverse and remand to the district court for further proceedings consistent with this opinion.

I.

The Arkansas assignment statute provides that:

> All bonds, bills, notes, agreements, and contracts, in writing, for the payment of money or property, or for both money and property, **shall** be assignable.

Ark. Code Ann. §4-58-102 (1987) (emphasis added). As interpreted by the Arkansas Supreme Court, this statute forces BCBS, as an insurer of ERISA plans, to honor all assignments of insurance benefits made by plan beneficiaries. *American Medical Int'l v. Arkansas Blue Cross & Blue Shield*, 773 S.W.2d 831, 834 (Ark. 1989). Prior to this state court interpretation of the assignment statute, BCBS had the contractual right to determine who received payment of welfare benefits:

> No assignment of benefits under this Certificate shall be valid until approved and accepted by the Plan. The Plan reserves the

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[1] ERISA, 29 U.S.C. §§1001-1461 (1988), is a comprehensive statute that sets certain uniform standards and requirements for employee benefit plans. ERISA covers both pension benefit plans, which provide employees with retirement income, id. §1002(2)(A), and welfare benefit plans, which provide employees with health, legal, vacation, or training benefits, id. §1002(1). This case deals only with the application of the assignment statute to welfare benefit plans.

> right to make payment of benefits, in its sole discretion, directly to the provider of service or to you.

Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc., No. LR-C-90-89, Mem. & Order at 2 n.2 (E.D. Ark. Dec. 19, 1990). BCBS used this contractual right to disapprove assignments made to health care providers who refused to sign a participation agreement with BCBS. St. Mary's Hospital, Inc. (St. Mary's), appellee, was such a provider. When a plan beneficiary of a BCBS-insured plan received services from St. Mary's, BCBS would pay the insurance benefits directly to the beneficiary. St. Mary's thus had the inconvenience of attempting to collect from the beneficiary. St. Mary's challenged this BCBS practice in state court. *American Medical Int'l*, 773 S.W.2d at 834. The Arkansas Supreme Court found for St. Mary's, holding that the assignment statute gave insureds the unconditional right to assign their welfare benefits. *Id.; see also American Medical Int'l v. Arkansas Blue Cross & Blue Shield*, No. E 87-414 (Ark. Ch. Ct. Aug. 26, 1991) (interpreting supreme court's decision on remand). Consequently, BCBS now must pay plan welfare benefits to whomever the plan beneficiaries assign this right, including St. Mary's.

BCBS challenged this application of the assignment statute to ERISA plans by bringing a declaratory judgment action in federal district court. BCBS argues that ERISA preempts this application of the statute. The ERISA preemption provision provides that:

> [T]he provisions of [ERISA] shall supersede any and all State laws insofar as they may now or hereafter **relate to** any employee benefit plan. . . .

29 U.S.C. §1144(a) (emphasis added). St. Mary's brought a motion to dismiss BCBS's action for declaratory judgment and BCBS filed a cross-motion for summary judgment.

The district court granted St. Mary's motion to dismiss, ruling that the assignment statute does not "relate to" ERISA plans merely because it negates a plan provision and has some economic impact on the plan. The court also found that the assignment statute did not affect the relationship between the plan participants or impact the administration of the plan. *Arkansas Blue Cross & Blue Shield*, No. LR-C-90-89, Mem. & Order at 5-6. Because ERISA preemption is a question of federal law involving statutory interpretation, we review the district court's decision de novo. *Boise Cascade Corp. v. Peterson*, 939 F.2d 632, 636 (8th Cir. 1991); *Local Union 598, Plumbers & Pipefitters Indus. Journeymen & Apprentices Training Fund v. J. A. Jones Constr. Co.*, 846 F.2d 1213, 1218 (9th Cir.), *aff'd mem.*, 488 U.S. 881 (1988). For the following reasons, we reverse.

II.

The first issue a court must address when deciding ERISA preemption cases, and the only issue before this court, is whether the state law in question "relates to"

ERISA plans.[2] The Supreme Court broadly interpreted the "relates to" language of the ERISA preemption provision in *Shaw v. Delta Air Lines*, 463 U.S. 85 (1983). The Court gave effect to the plain meaning of this language and stated that a law "relates to" an employee benefit plan "if it has a connection with or reference to such a plan." *Id.* at 96-97. The Court, however, also noted that "[s]ome state actions may affect employee benefits plans in too tenuous, remote, or peripheral a manner to warrant a finding that a law 'relates to' the plan." *Id.* at 100 n.21. The standard articulated in *Shaw* does not, and was not intended to, provide courts with a foolproof method for determining on which side of the preemption line a specific state statute falls.

Consequently, subsequent cases have relied on a variety of factors when determining whether a state statute of general application "relates to" ERISA plans.[3] These factors include whether the state law negates an ERISA plan provision, *Baxter v. Lynn*, 886 F.2d 182, 185 (8th Cir. 1989), whether the state law affects relations between primary ERISA entities, *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550, 556 (6th Cir. 1987); *Sommers*

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2. Even if the assignment statute "relates to" ERISA plans, it may be "saved" from preemption by 29 U.S.C. §1144(b)(2). This ERISA provision provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance. . . . " Id. We do not decide whether ERISA preempts the Arkansas assignment statute because the district court must first address whether the assignment statute is a state law that regulates insurance.

3. Statutes of general application, such as the Arkansas assignment statute, can be distinguished from statutes that actually or implicitly refer to ERISA plans. Courts have treated these statutes as having a "reference to" ERISA plans. See, e.g., Mackey v. Lanier Collections Agency & Serv., 486 U.S. 825, 829 (1988).

Drug Stores v. Corrigan Enters., 793 F.2d 1456, 1467 (5th Cir. 1986), whether the state law impacts the structure of ERISA plans, *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157, 1160 (9th Cir. 1986), whether the state law impacts the administration of the ERISA plans, *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9-10 (1987), whether the statelaw has an economic impact on ERISA plans, *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142, 147-48 (2d Cir. 1989), whether preemption of the state law is consistent with other ERISA provisions, *Mackey v. Lanier Collections Agency & Serv.*, 486 U.S. 825, 832-40 (1988), and whether the state law is an exercise of traditional state power, *Aetna Life Ins. Co.*, 869 F.2d at 148; *Firestone Tire & Rubber Co.*, 810 F.2d at 555.

This court agrees that all these factors can be relevant to an ERISA preemption analysis. Like any list of factors, however, they only serve to focus and clarify the court's analysis. The court must still look to the totality of the state statute's impact on the plan—both how many of the factors favor preemption and how heavily each individual factor favors preemption are relevant.

We do not believe that any one factor, by itself, is determinative of the ERISA preemption issue before the court today. Rather, given the aggregate of these factors, we find that the Arkansas assignment statute "relates to" ERISA welfare benefit plans. We will discuss each of these factors in turn.

A. Negation of a Plan Provision

BCBS argues that because the assignment statute negates a proper provision of an ERISA plan, the statute "relates to" ERISA plans. According to BCBS, once the court finds that a state law invalidates a plan provision, the court need not further analyze the law's impact on the plan. We decline to adopt negation of a plan provision as determinative of the preemption issue. Adoption of this standard could open the door for abuse of the ERISA preemptive provision. As the district court noted, if negation of a plan provision was the standard for ERISA preemption, parties could avoid any state law by including a contrary provision in an ERISA plan. *Arkansas Blue Cross & Blue Shield*, No. LR C-90-89, Mem. & Order at 5. Additionally, we do not believe that the statutory language or case law mandates such a rule.

Although arguably any statute that negates a plan provision "relates to" the plan, the Supreme Court has rejected carrying this language to its logical limits. In *Shaw*, 463 U.S. at 100 n.21, the Court stated "that [s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." Accordingly, a court must also address the relationship of the negated plan provision to the plan as a whole when determining if the state law's effect is "tenuous, remote, or peripheral."

Additionally, in *FMC Corp. v. Holliday*, 111 S.Ct. 403 (1990), the Supreme Court implicitly rejected nega-

tion of a plan provision as a sufficient basis for preemption. In *FMC*, the Supreme Court was faced with a state statute that negated a subrogation provision contained in an ERISA plan. Rather than relying on negation of the plan provision as a sufficient basis for preemption, however, the Court analyzed the statute's impact on plan administration. *Id.* at 408-09; *see also MacLean v. Ford Motor Co.*, 831 F.2d 723 (7th Cir. 1987) (court did not rely solely on the negation of a plan term in finding that ERISA preempted state testamentary law).

BCBS argues that the Eighth Circuit adopted a negation standard for preemption in *Baxter*, 886 F.2d at 185 (citing *Davis v. Line Constr. Benefit Fund*, 589 F.Supp. 146 [W.D. Mo. 1984]). We do not read *Baxter* as adopting such a test. Although the *Baxter* court stated that "any provision of state law which conflicts with a proper provision of an ERISA plan must give way to the latter," the court also relied on the state law's impact on the plan's structure in reaching its conclusion. *Id.* Additionally, the court cited a Ninth Circuit case that had found ERISA preemption of a state subrogation statute nearly identical to the statute before the *Baxter* court. *Id.* (citing *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157, 1160 [9th Cir. 1986]). In this case, the Ninth Circuit concluded that the state subrogation law "relates to" the ERISA plan because the law impacts the plan's structure; this case does **not** stand for the proposition that negation of a plan provision is a sufficient basis for preemption.

In sum, although negation of a proper plan provi-

sion is not determinative of ERISA preemption, the assignment statute's negation of the non-assignment clause does support a finding that the statute "relates to" ERISA plans.

B. Effect on Primary ERISA Entities and Impact on Plan Structure

In analyzing ERISA preemption issues, some courts have discussed the state law's effect on the relationship of primary ERISA entities—the employer, the plan, the plan fiduciaries, and the beneficiaries. *Sommers Drug Stores*, 793 F.2d at 1467. Other courts rely on the law's impact on the structure of ERISA plans. *United Food & Commercial Workers*, 801 F.2d at 1160. For purposes of analyzing whether the assignment statute "relates to" ERISA plans, we treat these two factors as identical.[4]

We believe that this factor strongly supports a finding that the assignment statute "relates to" ERISA plans. By negating a non-assignment clause, the assignment statute takes from the claims administrator who is a plan fiduciary, *e.g.*, *Buehler Ltd. v. Home Life Ins. Co.*, 722

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4. With respect to many ERISA preemption issues, these two factors are essentially two different ways of articulating the same impact on ERISA plans. For example, in United Food & Commercial Workers, the Ninth Circuit held that a state subrogation law "relates to" ERISA plans because it "prohibit[s] employers from structuring their employee benefit plans in a manner that requires reimbursement in the event of recovery from a third party." 801 F.2d at 1160. Alternatively, the court could have stated that the law "relates to" ERISA plans because it affects the relationship of ERISA entities by taking from the plan and giving to the beneficiaries the right to any recovery from third parties.

F.Supp. 1554, 1562-63 (N.D. Ill. 1989); *Benvenuto v. Connecticut Gen. Life Ins. Co.*, 643 F.Supp. 87, 90 (D.N.J. 1986), and gives to the beneficiaries control over who should receive payment of ERISA-welfare benefits.[5] The claims administrator no longer can pay the beneficiary rather than the assignee—regardless of whether its motivation in doing so is to provide leverage for bargaining with providers, to enforce a co-payment provision,[6] to avoid a conflicting assignment, to simplify procedures by issuing a single check, or to meet some other need. This change in plan structure and in the relationship between primary ERISA entities is not a "tenuous" impact on the plan. Simply because it is St. Mary's, as assignee, and not the plan beneficiaries, as assignors, who is challenging ERISA preemption does not change this fact.

C. Impact on Administration

A state statute can have both an intrastate and interstate impact on the administration of ERISA plans. We discuss these factors separately.

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5. Presumably, BCBS is the party who grants or denies claims and then issues payment in most BCBS-insured ERISA plans. Our conclusion that this factor supports preemption, however, does not change if some other party, such as the employer, is the claims administrator.

6. An insurer may use a non-assignment clause to help enforce an insurance co-payment provision. Some insurers provide for a co-payment structure to make beneficiaries more aware of health costs and limit unnecessary use. See Kennedy v. Connecticut Gen. Life Ins. Co., 924 F.2d 698, 699 (7th Cir. 1991). To avoid this structure, the provider can increase the cost of its services and then waive the beneficiaries' co-payment. Id. One tool insurers can use to prevent this practice is to refuse to honor the insured's assignment of benefits. This forces providers to collect directly from the insured, increasing the provider's risk of noncollection and discouraging the provider from evading the co-payment structure.

1. Interstate Impact on Plan Administration

By giving the plan beneficiaries sole control of assignments, the assignment statute imposes on the claims administrator the burden of determining whether and to whom the plan beneficiaries have made assignments and then paying the appropriate parties. St. Mary's argues that this impact on plan administration is "tenuous, remote and peripheral" because a mechanism is in place for notifying claims administrators of assignments to health care providers and, in fact, the normal procedure for claims administrators to pay the health care provider. The mechanism used to notify administrators of assignments to health care providers is a UB-82 form. J. A. at 110. Rather than relying on this indicator of assignment when processing claims, however, BCBS looks to the contract with the insured and the participating status of the provider to determine whether the provider or the insured is paid. J. A. at 111. Thus, application of the assignment statute to BCBS-administered plans would require that BCBS now rely on the UB-82 forms when processing claims.[7]

An additional burden is that beneficiaries could pay a provider with personal funds and assign their wel-

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7. It is possible that BCBS is not the claims administrator of all BCBS-insured ERISA plans. The record does not indicate what procedures are used by other claims administrators of BCBS-insured plans.

fare benefits to third parties. Such assignments would create numerous administrative hassles because there is no mechanism for providing the insurer with notice of these assignments and, potentially, the administrator would have to cope with conflicting assignments. Unfortunately, the record contains no evidence on the likelihood of third-party assignments by plan beneficiaries. Clearly, if health care providers required prepayment, assignment of welfare benefits to third parties would be more likely to occur. Given that BCBS's participation agreements prohibit providers from requiring prepayment, J. A. at 111, and that BCBS can refuse to honor assignments, historically there has been little opportunity for the beneficiaries of BCBS-insured plans to make third-party assignments. Absent preemption of the assignment statute, however, BCBS would have to honor such assignments and health care providers would have no incentive to enter into provider agreements that prohibited prepayment requirements. Under these circumstances, it is safe to assume that third-party assignments would increase and the corresponding administrative burden also would increase.

Courts apparently disagree whether a state statute that dictates how an administrator should distribute plan benefits has more than a tenuous impact on plan administration. The Seventh Circuit, in *MacLean*, 831 F.2d at 728, indicated that such an impact is not tenuous. The *MacLean* court held that ERISA preempted state testamentary law because this law required the plan administrator to distribute the deceased employee's pension as-

sets according to the employee's will rather than according to the method provided for in the plan. *Id.* Likewise, the assignment statute requires BCBS to distribute welfare benefits according to the beneficiaries' assignments rather than according to the method provided for in the ERISA plans. As the Seventh Circuit stated, this type of state law impact "interferes with the administration of the Plan." *Id.* On the other hand, *Mackey*, 486 U.S. at 831-40 (state garnishment law), and *Aetna Life Ins. Co.*, 869 F.2d at 147 (state escheat law), both found that state statutes affecting benefit distribution did not "relate to" ERISA plans. Both these cases, however, are distinguishable. Unlike the Arkansas assignment statute, state garnishment and escheat statutes do not shift control over benefit distribution. Neither do they negate a proper ERISA provision. Additionally, in *Mackey*, the Supreme Court significantly relied on a "sue and be sued" clause in the ERISA statute as support for its holding. The Court reasoned that because the "sue and be sued" clause contemplates execution of judgment but does not provide a method for doing so, state law methods for collecting money judgment must remain undisturbed. *Mackey*, 486 U.S. at 833-34. This "sue and be sued" language is not applicable to the voluntary assignment of ERISA benefits. Accordingly, *Mackey* does not control the issue before this court.

In sum, we believe that the assignment statute has an impact on intrastate plan administration. Although, in practical effect, this impact may not greatly burden plan administration and thus in itself would not be sufficient to

justify preemption, we believe that this factor supports a finding that the assignment statute "relates to" ERISA plans.

2. Interstate Impact on Plan Administration

State laws also can have an interstate administrative impact on ERISA plans because multi-state plans would be subject to the potentially conflicting laws of fifty different states. When an interstate administrative impact exists, it is a factor that strongly favors preemption. The Supreme Court has recognized that a main purpose of enacting ERISA and providing for pervasive federal preemption was to protect plan participants from the threat of conflicting and inconsistent state regulation. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9-10 (1987). The Court noted that "[t]he most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and **disbursement of benefits.**" *Id.* at 9 (emphasis added). Like intrastate administrative impact, however, some interstate administrative impact may be only tenuous. *Aetna Life Ins. Co.*, 869 F.2d at 147-48.

The record does not contain evidence on the interstate administrative impact of state assignment statutes. Clearly, some non-conformity is possible. For example, state laws may differ regarding the ability to limit contractually the right of assignment, when an assignment is valid, when and what type of notice must be given to the

obligor, and the priority of conflicting assignments. Such inconsistencies could raise numerous administrative difficulties for multi-state ERISA plans. Thus, although there is insufficient evidence for this factor to be dispositive of preemption, we believe that it supports a finding that the Arkansas assignment statute "relates to" ERISA plans.

Economic Impact

The district court noted that "a state law does not 'relate to' an ERISA plan merely because the law would have some economic impact on the plan." *Arkansas Blue Cross & Blue Shield*, No. LR-C-90-89, Mem. & Order at 6 (citing *Rebaldo v. Cuomo*, 749 F.2d 133 [2d Cir. 1984]). We agree that "tenuous, remote and peripheral" economic impact on ERISA plans, in itself, is not sufficient to find preemption. Like all the factors considered, however, simply because the existence of some economic impact is not dispositive of the preemption issue does not make this factor irrelevant to the preemption inquiry. In fact, this factor is highly relevant to whether the assignment statute "relates to" ERISA plans.

By requiring claims administrators to honor assignments to non-participating providers, the assignment statute eliminates the health care providers' incentive to enter into participation agreements. Accordingly, the issue is whether participation agreements collectively can have an economic impact on ERISA plans. We believe they can. For example, BCBS uses participation agreements to implement a hospital reimbursement program

developed around the concept of reimbursing a "fair market price for a defined unit of service." J. A. at 38-39. The principal intent of this program is to reward efficient providers of services and provide incentives for hospitals with charges exceeding peer group norms to strive to bring the price of their services back within reasonable limits. *Id.* By promoting efficiency, BCBS hopes to obtain lower health care costs. Whether lower health costs would result in lower premiums for employers, higher benefits for employees, higher profits for the insurer, or some combination of these consequences, *cf. Aetna Life Ins. Co.*, 869 F.2d at 147 (discussing economic impact of state escheat statute), there is an economic impact on ERISA plans.

Although BCBS did not present any evidence that its program has been successful,[8] we find it highly unlikely

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[8] St. Mary's argues that BCBS admitted in Interrogatory No. 8, J. A. at 42, that there was no economic impact associated with the non-assignment clause. Tr. at 13. This interrogatory asked whether BCBS's ability to hold down health care costs would be impaired if BCBS lost subscribers and/or insureds. We do not read BCBS's response of "no" as an admission that the non-assignment clause has no economic impact on ERISA plans. BCBS's argument as to economic impact relates to the loss of participating providers, not to the loss of subscribers and/or insureds. Additionally, BCBS consistently asserted and explained the economic impact of the non-assignment clause in its response to other interrogatories. J. A. at 37-42.

St. Mary's also relies on the state court action between St. Mary's and BCBS to support its argument that the non-assignment clause does not have an economic impact. The state court ruled that BCBS failed to prove that its program was an effective method of reducing costs. American Medical Int'l v. Arkansas Blue Cross & Blue Shield, No. E 87-414, Final Decree at 3 (Ark. Ch. Ct. Aug. 26, 1991). The state court also stated that the method employed by BCBS "would certainly have some effect" on health care costs. Id. Accordingly, the state court must have found this effect insufficient to override the Arkansas Assignment Statute on public policy grounds. Because this court is asking a different question—whether the use of non-assignment clauses in general could have a sufficient economic impact on ERISA plans to support a finding that the assignment statute is "related to" ERISA plans—the state court ruling is not dispositive.

that health care providers, such as St. Mary's, would refuse to enter participation agreements if doing so had no economic impact.[9] Moreover, giving effect to the assignment statute forecloses BCBS from further refining its program and prevents other ERISA-plan insurers and employers from instigating programs that use participation agreements to control health care costs. We do not believe that Congress could comprehensively preempt all state laws that relate to ERISA plans, but still leave the door open for states to strike a fatal blow to participation agreements. Accordingly, this factor supports a finding that the assignment statute "relates to" ERISA plans.

E. Other Statutory Provisions

Another factor helpful in determining an ERISA preemption question is whether ERISA preemption of the state law in question is consistent with other relevant ERISA provisions. Arguably, one such provision is 29 U.S.C.A. §1056(d)(1), which provides that "each pension plan shall provide that benefits provided under the plan may not be assigned or alienated." Although the Supreme Court found this provision relevant in addressing ERISA preemption of state garnishment laws, *Mackey*, 486 U.S. at 837, the Court's analysis does not apply to assignment statutes.

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9. In fact, one reason St. Mary's refused to enter a participation agreement is that it would have prohibited St. Mary's from proceeding against the plan beneficiaries for monies due St. Mary's over and above the policy limits. See American Medical Int'l, No. E 87-414, Final Decree at 3.

In *Mackey*, the Supreme Court reasoned that because Congress expressly prohibited assignment of pension benefits but did not expressly prohibit assignment of welfare benefits, Congress must have intended to allow garnishment of welfare benefits. This reasoning is not applicable to the Arkansas assignment statute. Congress' failure to dictate the assignability or non-assignability of welfare benefits does not mean that Congress left the door open for states to impose such a rule. If Congress intended that a mandatory rule govern the assignment of welfare benefits, it could have easily provided for such a rule, as it did in the case of pension benefits. On the other hand, if Congress intended that ERISA participants could negotiate plan provisions governing the right to assign welfare benefits, it is more likely that Congress would say nothing at all about welfare benefit assignment. This same logic does not apply to ERISA's failure to address garnishment of welfare benefits. Because the creditors of beneficiaries are not parties to ERISA plans, an ERISA plan provision cannot govern a creditor's right to garnishment. Thus, Congress could not have intended that ERISA plans govern the right of creditors to garnish benefits.

A further factor distinguishing *Mackey* is that ERISA preemption of state garnishment laws would essentially prohibit all involuntary assignments of pension and welfare benefits. Thus, the preemption provision would largely overlap the pension benefit anti-assignment provision. *Mackey*, 486 U.S. at 837. ERISA preemption of state assignment statutes, on the other hand, will not

preclude the voluntary assignment of welfare and pension benefits. ERISA plans could still allow voluntary assignments. Therefore, the pension benefit anti-assignment provision remains necessary to prohibit the assignment of pension benefits.

In fact, the pension benefit anti-assignment provision actually supports a finding that the assignment statute "relates to" ERISA plans. The legislative history of ERISA indicates that Congress intended to preempt the field of employee benefit law. *See Shaw*, 463 U.S. at 99 (citing from 120 Cong. Rec. 29197, 29933 [1974]). The fact that Congress explicitly addressed the assignability of pension benefits in ERISA indicates that the issue of benefit assignment, whether pension or welfare, is within the area of law Congress intended to preempt.

F. Exercise of Traditional State Power

We reject St. Mary's argument that preemption is not appropriate because the assignment statute is an exercise of traditional state power. *See Boise Cascade Corp. v. Peterson*, 939 F.2d 632, 637-38 (8th Cir. 1991) (rejecting the state's argument that ERISA does not preempt a state minimum jobsite ratio rule because it fell within the traditional state area of protecting public safety). Like the Fifth Circuit, we are "not convinced that . . . the traditional or nontraditional nature of the state law . . . properly bears upon the question whether a state law of general application affects a benefit plan in so tenuous, remote, or peripheral way that it cannot be said to 'relate

to' the plan." *Sommers Drug Stores*, 793 F.2d at 1468; *see also Gilbert v. Burlington Indus.*, 765 F.2d 320, 327 (2d Cir. 1985) ("to avoid preemption it is not sufficient that the state statute represent the exercise of a traditional state police power. . . . "). Although the Supreme Court has not discussed the relevance of this factor, its failure to consider this criterion when deciding ERISA preemption cases is telling. *See FMC Corp. v. Holliday*, 111 S.Ct. 403 (1990) (state subrogation law); *Mackey v. Lanier Collections Agency & Serv.*, 486 U.S. 825 (1988) (state garnishment law).

Although a state law's relationship to traditional state authority is not relevant to whether a state statute "relates to" ERISA plans, this factor arguably is a policy consideration useful in deciding borderline questions of ERISA preemption. Assuming that ERISA preemption of the assignment statute is such a case, this factor does not strongly favor a finding of no preemption. St. Mary's argues that assignment statutes are within the traditional province of states because such laws have been on the books for a long time and are of general applicability. We do not find either of these factors persuasive. ERISA preemption of the assignment statute would not render the law invalid, but would only prohibit application of the law to ERISA-plan welfare benefits. Given that the Arkansas Insurance Department authorized BCBS's reimbursement program, which utilizes non-assignment clauses, J. A. at 38, we do not believe that Arkansas has a strong interest in preventing parties from contractually limiting the right to assign ERISA-plan welfare benefits.

Alternatively, St. Mary's argues that because one goal of BCBS's non-assignment clause is to keep health care costs down and regulation of health care costs is an area of traditional state concern, ERISA must not preempt the state assignment statute. To support this argument, St. Mary's relies on *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), which held that ERISA does not preempt a state statute directly regulating health care costs. *Id.* at 138. This argument is misplaced. The Arkansas assignment statute does not directly regulate health care costs. The only arguable impact the assignment statute has on health care costs is that it prevents BCBS, and any other ERISA-plan insurer or employer who may want to do so, from using a non-assignment clause as leverage when negotiating with health care providers. Interference with such negotiations is not an area of traditional state concern. Even if it were, such interference is certainly not the intended purpose of the assignment statute.

In sum, we do not believe that whether the assignment statute is an exercise of traditional state authority favors or disfavors a finding of preemption.

III.

In summary, we reverse the district court and hold that the assignment statute "relates to" ERISA plans. We do not find any one of the above factors, in itself, determinative of the issue before the court. Rather, we base our decision on the totality of the statute's impact—nega-

tion of a proper plan provision, impact on the relationship of primary ERISA entities, impact on the intrastate and interstate administration of ERISA plans, and economic impact on the plan. It is all of these factors together that make the assignment statute's affect on ERISA plans not "tenuous, remote, or peripheral."

We remand to the district court the issue of whether BCBS waived the preemption issue by not raising it in the state court proceedings. If waiver is found, BCBS is bound by the state court judgment for damages, but not by the injunction requiring BCBS to honor all assignments of ERISA-plan welfare benefits. We also remand to the district court the issue of whether the assignment statute is saved from ERISA preemption under 29 U.S.C. §1144(b)(2), as a state law regulating insurance. If the district court finds that the assignment statute is not preempted, the state court judgment is fully effective.

A true copy.

Attest:

Clerk, U. S. Court of Appeals, Eighth Circuit

APPENDIX II

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

Arkansas Blue Cross and Blue Shield,
A Mutual Insurance Company *Plaintiff*

vs. No. LR-C-90-89

St. Mary's Hospital, Inc. *Defendant*

Memorandum & Order

Pending before this Court are the motion to dismiss[1] filed by defendant St. Mary's Hospital, Inc. (hereinafter "St. Mary's") and the cross-motion for summary judgment filed by plaintiff Arkansas Blue Cross and Blue Shield (hereinafter "Blue Cross").

On July 27, 1987, a declaratory judgment action was brought by St. Mary's and its parent company, American Medical International (hereinafter "AMI"), against Blue Cross in the Circuit Court of Pope County, Arkansas to determine whether Blue Cross could refuse to honor assignments of insurance benefits by patients in favor of

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1. The Court will treat St. Mary's motion to dismiss as a motion for summary judgment since the motion presents matters outside the pleadings. See Fed. R. Civ. P. 12(b).

St. Mary's. Blue Cross has refused to honor the assignments and is making payments of policy benefits directly to the insureds rather than the hospital. Blue Cross acknowledges that it will not honor the assignments because of the failure of St. Mary's to enter into a provider contract with Blue Cross. Blue Cross contends that the provider contract is designed to contain the costs of medical care for its insureds by requiring the hospital to follow certain Blue Cross procedures and policies. Blue Cross bases its right to refuse to honor the assignments on a provision of the insurance contracts between Blue Cross and its insureds which gives Blue Cross the right to approve or disapprove assignments made by the insureds.[2]

The Circuit Court of Pope County held that the Arkansas Insurance Code permitted the contractual provision which gives Blue Cross the right to refuse to honor a patient assignment.[3] The Arkansas Supreme Court re-

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2. The approval of assignments provision reads as follows:

> No assignment of benefits under this certificate shall be valid until approved and accepted by the Plan. The Plan reserves the right to make payment of benefits, in its sole discretion, directly to the provider of service or to you.

3. The Arkansas Insurance Code provisions at issue in the state court action provide:

> (b) the following provisions, or either of them, may be included with the foregoing provision at the option of the insured:
>
> (1) . . .
>
> (2) "Subject to any written direction of the insured in the application or otherwise, all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the serv-

versed the trial court and held that the general Arkansas law permitting assignments rather than the Arkansas Insurance Code applied to this action.[4] The Court held that the assignments were valid and Blue Cross could be required to honor the assignments. *See American Medical International, Inc. v. Arkansas Blue Cross and Blue Shield*, 299 Ark. 514, 773 S.W.2d 831 (1989). The Court remanded the action to the circuit court where the parties are awaiting trial on the public policy issues.[5]

Blue Cross brought this action on February 8, 1990, seeking a declaratory judgment that the Employee

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ice be rendered by a particular hospital or person."

Ark. Code Ann. §23-85-114(b)(2) (1987).

> (a) Any group disability policy may, on request by the group policy-holder, provide that all or any portion of any indemnities provided by any policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the service be rendered by a particular hospital or person.
>
> (b) Payment so made shall discharge the insurer's obligation with respect to the amount of insurance paid.

Ark. Code Ann. §23-86-112 (1987).

4. The general Arkansas assignment law provides:

> All bonds, bills, notes, agreements, and contracts, in writing, for the payment of money or property, or for both money and property, shall be assignable.

Ark. Code Ann. §4-58-102 (1987).

5. The Supreme Court did not consider the public policy arguments advanced by Blue Cross. Although the issues were raised at the trial court level, they were not reached here.

Retirement Income Security Act of 1974 (hereinafter "ERISA") preempts state law from nullifying provisions of Blue Cross ERISA plans which provide that the insurer may approve or disapprove of an insured's assignment of policy benefits. At no time in the state court action did Blue Cross raise the preemption issue. St. Mary's contends that Blue Cross is now precluded from raising the issue of preemption. Alternatively, St. Mary's argues ERISA does not preempt the general Arkansas law on assignments in this area because it does not "relate to an employee benefit plan."

For the reasons set forth below, the Court holds that the general Arkansas assignment law is not preempted in this area. Therefore, the Court need not decide whether Blue Cross waived the preemption issue by failing to raise it at the state court level as the Court finds that Blue Cross would not prevail even if no waiver occurred.

The preemptive scope of ERISA is broad. *See Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 729 (1985). ERISA preempts state law if the state law "relate[s] to any employee benefit plan . . . " and is not otherwise exempt under ERISA. 29 U.S.C. §1144(a). A state law "relates to" any employee benefit plan "if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983). A state law need not expressly deal with ERISA plans in order to be preempted. *Baxter v. Lynn*, 886 F.2d 182, 185 (8th Cir. 1989). However, this preemption does not reach every

law that has an effect on an ERISA plan. The effect of certain state laws on plans are so remote and tenuous as not to be preempted. *See Shaw*, 463 U.S. at 100 n. 21 (citing *American Telephone and Telegraph v. Merry*, 592 F.2d 118, 121 [2d Cir. 1979]).

No specific test has been formulated to determine on which side of the preemption line a particular state law falls. Courts have looked to various factors such as whether the state law directly conflicts with a provision in the plan, whether the state law represents a traditional exercise of state authority, whether the state law affects relations among the principal ERISA entities, and whether the effect on the ERISA plan is incidental or whether it affects the plan administration itself. *See Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989); *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987); *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985).

Having carefully considered such factors, the Court concludes that the Arkansas assignment law is not preempted by ERISA. While it is true, as Blue Cross points out, that the Arkansas Supreme Court's interpretation of the assignment law would negate the approval of assignments provision, this effect alone is not determinative of the preemption question before the Court. If such were the case, an insurer, wishing to circumvent a particular state law, could insert a provision in ERISA plans which conflicted with the state law and then could argue that the state law was preempted by ERISA.

Moreover, the Court finds *Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989), cited by Blue Cross, to be distinguishable from the present case. The state common law at issue in *Baxter* restricted subrogation rights. The ERISA plan provided a right of subrogation to the plan for any recovery from third parties by plan participants. In affirming the district court's holding that the state law was preempted, the Eighth Circuit stated that "[a]ny state law prohibiting employers from structuring their employee benefit plans in a manner that requires reimbursement in the event of recovery from a third party creates a conflict with . . . the Fund's employee benefit plan." *Id.* at 185. The state law in *Baxter* affected the relationship between parties to an ERISA plan—the employer and the plan participant.

Blue Cross admits in its brief in support of its cross-motion for summary judgment that the purpose of the right to approve assignment provisions of its ERISA plans is to give "Blue Cross leverage in negotiating with hospitals to enter into provider contracts. . . . " Brief in Support of Plaintiff's Cross-Motion for Summary Judgment, at 2-3 (Pleading #8). This provision in the plans does not affect the relationship between the parties to an ERISA plan or impact on the administration of the plan. It is not related to the structure or general functioning of an ERISA plan. Its purpose is to provide Blue Cross with a negotiating tool as to a third-party, the hospital.

The Court is not persuaded by Blue Cross's argu-

ment that the assignment law will impact administration of ERISA plans because it will not allow Blue Cross to effectuate its hospital cost containment procedures for the benefit of its insureds. A state law does not "relate to" an ERISA plan merely because the law would have some economic impact on the plan. *See Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1979). Such a relationship to an ERISA plan is too tenuous. Therefore, the Court holds that the general Arkansas assignment law is not preempted by ERISA.[6] The law's effect on an ERISA plan is insubstantial.

It is, therefore, ORDERED that defendant's motion to dismiss is granted, plaintiff's cross-motion for summary judgment is denied, and plaintiff's complaint is hereby dismissed with prejudice.

It is SO ORDERED this 18th day of December, 1990.

STEPHEN M. REASONER
United States District Judge

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6. Since the Court finds that the assignment law does not "relate to" an employee benefit plan, the Court need not consider defendant's alternative argument that the law is "saved" from ERISA preemption under 29 U.S.C. §1144(b) as a state law regulating insurance.

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

Arkansas Blue Cross and Blue Shield,
A Mutual Insurance Company *Plaintiff*

vs. No. LR-C-90-89

St. Mary's Hospital, Inc. *Defendant*

Judgment

In accordance with the Memorandum and Order entered this date, Judgment is entered in favor of defendant, St. Mary's Hospital, Inc., and against plaintiff Arkansas Blue Cross and Blue Shield, and plaintiff's complaint is hereby dismissed with prejudice.

It is SO ORDERED this 18th day of December, 1990.

STEPHEN M. REASONER
United States District Judge

APPENDIX III

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 91-1097EALR

Arkansas Blue Cross and Blue Shield,
A Mutual Insurance Company,

Appellant

vs.

St. Mary's Hospital, Inc.,

Appellee.

ORDER DENYING PETITION FOR REHEARING
AND SUGGESTION FOR HEARING EN BANC

The suggestion for rehearing en banc is denied. The petition for rehearing is also denied.

January 13, 1992

Order entered at the Direction of the Court:
MICHAEL E. GANS
Clerk, U. S. Court of Appeals, Eighth Circuit

APPENDIX IV

SUPREME COURT OF ARKANSAS

American Medical International, Inc.
and St. Mary's Hospital, *Appellants*

v. No. 88-259

Arkansas Blue Cross and Blue Shield,
A Mutual Insurance Company, *Appellee*

HOLT, *Chief Justice:*

Appellant St. Mary's Hospital is a wholly owned subsidiary of separate appellant American Medical International ("AMI"). In 1987, St. Mary's and AMI brought suit against appellee Arkansas Blue Cross and Blue Shield ("ABCBS") seeking a declaratory judgment as to whether ABCBS could refuse to honor patient assignments of insurance benefits to medical care providers such as St. Mary's. Summary judgment was entered in favor of ABCBS premised on a right to disallow assignments. St. Mary's brings this appeal. We reverse.

St. Mary's Hospital admitted several patients in 1987 who were insured by ABCBS and who were in need of the hospital's services. Apparently, the admission forms provided by St. Mary's and completed by its patients contain provisions whereby the patients authorize direct payment to the hospital of any indemnity insurance bene-

fits otherwise payable to the insureds for services rendered by the hospital. Other provisions purport to actually assign the benefits for application to the patients' bills. On the other hand, the insurance contracts or policies written by ABCBS and executed by its insureds apparently contain provisions whereby indemnities or proceeds payable under the policies may be assigned only upon approval by ABCBS.

Acting pursuant the language in its admissions forms, St. Mary's, as purported assignee of the right to its patients' insurance benefits, sought payment from ABCBS. ABCBS refused to honor the assignments for two reasons. First, the assignments had not been approved as required in ABCBS's contracts with its insureds. Second, in its pleadings, answers to interrogatories, and admission of fact, ABCBS conceded a practice whereby patient assignments of insurance benefits by its insureds were not honored if the assignee hospital did not have a "provider contract" with ABCBS. The terms of the provider contracts are not relevant to this appeal; suffice it to say, St. Mary's has no such contract with ABCBS. Suit followed upon ABCBS's refusal to honor the assignments.

The public policy issues concerning an insured's interest in freely assigning the right to payment versus ABCBS's freedom of contract and its right to include provisions against assignment were raised below but were never reached. Both parties moved for summary judgment arguing that the result in this case was controlled by

certain of our code provisions.

St. Mary's maintained below that Ark. Code Ann. §4-58-102 (1987) governed the outcome. That section provides:

> All bonds, bills, notes, agreements, and contracts, in writing, for the payment of money or property, or for both money and property, shall be assignable.

St. Mary's further argued that, as a defense, ABCBS would rely on Ark. Code. Ann. §23-85-114(b)(2) (1987), part of the Arkansas Insurance Code, which provides:

> The following [provision] may be included with [foregoing provisions in a policy of insurance] at the option of the insurer:
>
> Subject to any written direction of the insured in the application or otherwise, all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person.

St. Mary's position in its motion for summary judgment was that the assignment statute, section 4-58-102, controlled the assignability of insurance proceeds

and that Ark. Code Ann. §23-85-114(b)(2) did not operate to repeal, amend or alter the law in this regard. ABCBS, in its own motion for summary judgment, responded that section 23-85-114(b)(2) in fact amended the law on assignability, at least in the field of insurance. ABCBS also relied upon Ark. Code Ann. §23-79-124 (1987), which in subsection (a) provides:

> A policy may be assignable or not assignable, as provided by its terms.

At the hearing on the cross-motions for summary judgment, ABCBS cited Ark. Code Ann. §23-86-112 (1987) as further support. This section provides:

> Any group disability policy may, on request by the group policyholder, provide that all or any portion of any indemnities provided by any policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services; but the policy may not require that the service be rendered by a particular hospital or person.

In ruling upon the underlying issue of whether ABCBS could lawfully refuse to honor patient assignments, the chancellor sought to determine whether: (1) the code provisions cited by ABCBS give an insurer the option of paying either the provider or the insured; (2) if so, do those provisions conflict with the general law on assignability; and (3) in that event, do the insurance code provi-

sions repeal the law on assignability to the extent the laws conflict?

In his decree, the chancellor rules there was an irreconcilable conflict between the insurance code provisions and the general law on assignability (no mention was made of section 23-79-124). He further concluded the insurance code provisions repealed the general law to the extent of any inconsistency. The chancellor's decree contains the following language:

> An individual insured, as opposed to a person covered under a group policy, may, by a timely written direction, prevent an insurer from making payment directly to the provider of services; however, an individual insured is not empowered by that statute to compel an insurer to pay directly to a provider. . . . *The ABCBS policies, as authorized by statute . . . reserve to ABCBS the option to pay a provider directly, or to pay the covered person.* [Emphasis ours.]

On appeal, St. Mary's makes three arguments with several subdivisions. First, it is argued that as a matter of law the chancellor erred as to which code provision controls and whether the provisions actually conflict. St. Mary's contends the code provisions can be read together and argues the insurance code provisions apply only to the direction of payment by an insurer, not an insured's ability to assign "the right to receive payment."

St. Mary's second point on appeal is identical to its

first but applies to group polices rather than individual policies. On this issue, St. Mary's additionally argues the court erred in granting summary judgment because this was an "11th hour" argument by ABCBS and because there remained a genuine issue of fact as to the definition of "policyholder" as that term is used in the ABCBS policies, in Ark. Code Ann. §23-86-112 (1987), and in the ABCBS provider contracts.

St. Mary's third and final argument is that the chancellor's ruling conflicts with the intent and purpose of the insurance code. We need not reach this issue as it was not raised below. Arguments made for the first time on appeal will not be addressed by this court. *O'Bryant v. Horn*, 297 Ark. 617, 764 S.W.2d 445 (1989).

Section 23-85-114(b)(2), relied upon by the chancellor and by ABCBS, provides that subject to any written direction of the insured in the application or otherwise, all or a portion of any indemnities provided by a policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person. We give the words their usual and ordinary meaning, and if there is no ambiguity we give the provision effect just as it reads. *Woodruff v. Shockey*, 297 Ark. 595, 764 S.W.2d 431 (1989); *Chandler v. Perry-Casa Public Schools*, 286 Ark. 170, 690 S.W.2d 349 (1985).

Clearly, section 23-85-114(b)(2) provides the insurer with the option of drafting insurance policies to stipulate that payment shall be made to the provider of the medical care services rather than to the insured. The apparent purpose underlying the legislation is to assist hospitals or health service agencies in receiving payment for services provided. Equally clear is that the insured can prevent the payment of benefits to the provider by so requesting, in writing, at the time of application or when submitting proof of loss. The section therefore contemplates that the insurer's option to direct payment is governed by the will of the insured, so long as the insured is timely in his request. Finally, the section provides that any exercise by the insurer of his option to make payment directly to the provider of services should have no effect on the insured's choice of hospitals or care providers.

The chancellor concluded section 23-85-114(b)(2) does not authorize the insured to "compel" the insurer to pay the provider. Simply because this section does not provide that an insured may compel payment to be made to the provider does not mean other code provisions, such as the law on assignments, might not allow the insured to do so.

The obvious effect of section 23-85-114(b)(2) is that the insured gets paid directly, unless the insurer prefers to pay the provider, so long as the insured does not object. For the most part, this provision exists for the purpose of allowing the parties to directly benefit the

provider and in no way conflicts with section 4-58-102, which similarly would allow insureds to directly benefit medical care providers by assigning their right to receive insurance proceeds. For this reason, we conclude that the chancellor erred in ruling that such a conflict existed and erred in ruling that the insurance code provisions repealed the general law on assignments. In sum, we find no conflict between sections 23-85-114(b)(2) and 4-58-102.

Because the chancellor erroneously determined that there was an irreconcilable conflict between sections 23-85-114(b)(2) and 4-58-102 causing the insurance code provisions to repeal the general law on assignments, we reverse for proceedings not inconsistent with this opinion.

Reversed.

APPENDIX V

IN THE CHANCERY COURT
OF POPE COUNTY, ARKANSAS

American Medical International, Inc.
and St. Mary's Hospital — *Petitioners*

vs. No. E 87-414

Arkansas Blue Cross and Blue Shield,
a mutual insurance company — *Respondent*

Final Decree

Now on this day comes on for hearing, the Petition of the Plaintiffs, American Medical International, Inc. and St. Mary's Hospital, upon remand from the Arkansas Supreme Court. From the pleadings, testimony and exhibits offered, statements of counsel, and other matters, all of which the Court has carefully considered, IT IS, BY THE COURT, CONSIDERED, ORDERED, ADJUDGED AND DECREED THAT:

1. The Supreme Court has already determined the issue of the Defendant's right to refuse to honor assignments of monies payable to the insured and assigned to the Plaintiff in its July 17, 1989 opinion. In particular, the Supreme Court held that "[Ark. Code Ann. §23-85-114(b)(2){]} contemplates that the insurer's option to direct payment is governed by the will of the insured, so long as the insured is timely in this request . . . " and

that " . . . Simply because this section does not provide that an insured may compel payment to be made to the provider does not mean that other code provisions, such as the law on assignments, might not allow the insured to do so." This last statement was in referenced to Ark. Code Ann. §4-58-102, and the statements taken together cannot be interpreted in any manner other than to state that the Defendant wrongfully refused to honor the monies assigned to Plaintiff by the insured.

2. The Court takes into consideration that under normal contract law, parties are entitled to contract as they wish, but in a regulated industry many of the individual rights to contract are removed or become regulated by statute. These statutes and rights were interpreted by the Supreme Court in the July 17, 1989 opinion and covered in the preceding paragraph.

3. The Court recognizes that there is a strong public policy toward reducing the cost of medical services. While the method employed by the Defendant would certainly have some effect, the Court finds that the proof offered by the Defendant falls short of proving that it is an effective method of reducing cost in view of health care standards for the State of Arkansas, and Defendant's proposed public policy does not override the insured's right to assign insurance proceeds under Ark. Code Ann. §4-58-102 as interpreted by the Arkansas Supreme Court.

4. According to the Supreme Court's July 17, 1989 opinion, the general law of assignments, Ark. Code Ann.

§4-58-102, governs both group policies and individual subscriber contracts. Therefore, the insured will have the right to assign benefits regardless of the policy language. Furthermore, this Court finds that under the Supreme Court's decision, Ark. Code Ann. §23-79-124 does not prevent an insured's right of assignment.

5. The Court recognizes the obligation of parties to avoid or mitigate damages whenever and wherever possible. Defendant has alleged that Plaintiffs could have executed a participating hospital agreement during the pendency of this action thereby reducing its losses from patients who received the payments, but refused to forward the payments to the provider. The Court rejects this argument for the reason that the execution of such an agreement would have prohibited the provider from proceeding against the insured for monies due Plaintiff over and above the policy limits. Conversely, the Defendant has the option of making payment on the assignment directly to the provider, the Plaintiff, instead of the insured, thereby eliminating the danger of having to pay the same benefits again. Once Plaintiff put Defendant on notice of the assignment, the Plaintiff had no right against the insured other than to request payment. Plaintiff no longer had the right to proceed against the insured. The Court rules against the Defendant on the issue of avoidance of damages, and the Plaintiffs have met their burden of proof on the validity of the assignments.

6. On June 1, 1991, Defendant shall commence honoring assignment of insurance proceeds in favor of

Plaintiffs. This is a restatement of the Court's May 28, 1991 Order.

7. Damages will be awarded prospectively from the date of the Appellate decision, July 17, 1989. Plaintiff's claim for statutory penalties and attorneys fees is denied.

8. AMI and St. Mary's have asserted claims for damages against BCBS in the amount of $297,935.08. The parties agree as to the individual figures which compromise the claim, but differ as to the proper methodology to be applied by the Court in order to arrive at a final damage amount.

9. AMI and St. Mary's contend that they are entitled to damages equal to the lesser of the patient balance or the amount paid by BCBS to the patient directly. The application of this methodology would give AMI and St. Mary's first credit for all amounts paid by the patient. AMI and St. Mary's contend that this methodology is appropriate, asserting that the presence of balances due are a direct result of BCBS' refusal to honor St. Mary's patient assignments and that AMI and St. Mary's collection efforts should be applied to patient deductibles and co-insurance before applying such funds to the insured portion of the claim. In addition, AMI and St. Mary's claim damages for, and have included in their total claim, all payments made by BCBS directly to patients after July 17, 1989, regardless of admission date. AMI and St. Mary's also claim damages for, and have included in their total claim, those fees paid by St. Mary's to collection

agencies to collect the sums from the patients.

10. BCBS contends that, if AMI and St. Mary's are entitled to an award of damages, the proper amount is less than the total claim asserted by AMI and St. Mary's. BCBS contends that it should first receive credit for any amounts paid by the patient up to an amount equal to the amount paid to the patient by BCBS and, for those patients who paid amounts equal to or greater than the BCBS payment amounts, AMI and St. Mary's are not entitled to damages for those accounts. BCBS also contends that it is not responsible for those assignments made pursuant to hospital admission dates prior to July 17, 1989, regardless of BCBS payment date and that BCBS should not be responsible for collection agency fees paid by St. Mary's to collect outstanding monies due. The Court has considered the arguments of counsel as to the proper methodology to be utilized in determining a final damage figure.

11. There is also a dispute as to the proper interpretation to be given this Court's May 15, 1991 ruling. This Court interprets its May 15, 1991 ruling as requiring BCBS to pay to St. Mary's directly any and all payments pursuant to patient assignments of insurance proceeds payments of which are due on or after June 1, 1991, regardless of admission or assignment date. Beginning on August 8, 1991, BCBS is hereby directed to make payment directly to St. Mary's, regardless of admission date. For those claims with admission or assignment dates for all payments pending after July 17, 1989 prior to June 1,

1991, which BCBS has paid insurance proceeds to patients directly, the parties are directed to maintain records and an accounting of all amounts and those amounts will be appropriately credited between the parties at the conclusion of this matter following a remand, if any, from the Arkansas Supreme Court. Similarly, any monies paid to St. Mary's from the patients will be credited to BCBS as set out in paragraphs 10, 13 and 14 above.

12. This Court previously ruled during the May 15, 1991 hearing that AMI and St. Mary's are entitled to damages prospectively beginning on July 17, 1989. July 17, 1989 was the date of the ruling of the Arkansas Supreme Court, which held, as interpreted by this Court, that BCBS' refusal to honor St. Mary's patient assignments of insurance proceeds was invalid or in error. This Court interprets its may 15, 1991 ruling to mean that all payments made by BCBS to patients directly on or after July 17, 1989 shall be included in AMI and St. Mary's damage award, regardless of admission or assignment date. The total of those payments equals $23,489.46 and is properly included in AMI and St. Mary's claim for damages.

13. BCBS is liable to AMI and St. Mary's for damages of $253,626.08 which is derived from St. Mary's damage claim of $297,935.08, as more particularly set forth below:

a. BCBS shall be given first credit against such amount for all patient payments collected by St.

Mary's up to the amount of the claim asserted against BCBS, i.e., the amount BCBS paid its insured. The amount of such credits equals $27,966.73 and is deducted from AMI and St. Mary's damage claim.

b. In the event that the patient has paid St. Mary's an amount equal to or greater than the BCBS payment, BCBS owes AMI and St. Mary's no damages on those claims. The amount of credit to which BCBS is entitled equals $16,342.27 and is deducted from AMI and St. Mary's damage claim.

14. Because BCBS received credit for those payments collected by St. Mary's pursuant to its collection efforts, BCBS is also responsible for all collection agency fees incurred by AMI and St. Mary's in collecting those debts. That amount equals $5,237.69, which is properly included in AMI and St. Mary's damage claim.

15. AMI and St. Mary's are hereby entitled to and this Court does grant a judgment in their favor against BCBS in the amount of Two Hundred Fifty-three Thousand Six Hundred Twenty-six and 08/100 ($253,626.08), together with pre-judgment interest thereon in the rate of six percent (6%) per annum from the date of the claim, together with post-judgment interest thereon at the rate of ten percent (10%) per annum until such time as the judgment is fully and finally satisfied. AMI and St. Mary's are entitled to any and all writs of garnishment, writs of execution, or other writs which may issue in an effort to

assist AMI and St. Mary's in the collection of this judgment.

16. BCBS' Motion for New Trial should be and hereby is denied.

BE IT SO ORDERED.

ANDRE E. MCNEIL
Chancellor
Dated: August 20, 1991

AGREED:

CHARLES R. NESTRUD, ABN 77095
JANIE W. MCFARLIN, ABN 86175
CHISENHALL, NESTRUD & JULIAN, P.A.
400 W. Capitol, Suite 2840
First Commercial Bank Building
Little Rock, Arkansas 72201
(501) 372-5800

ALLEN GORDON
BART VIRDEN
GORDON & GORDON
P. O. Box 558
Morrilton, Arkansas 72110